DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 3 - 0 0 3

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: April 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 483.12

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ No Budget Impact
b. FFY 2004 $

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-C, p. 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-C, p. 1

10. SUBJECT OF AMENDMEN:
PAYMENT FOR RESERVED BEDS

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Mark Trail

13. TYPED NAME: MARK TRAIL

14. TITLE: CHIEF, MEDICAL ASSISTANCE PLANS

15. DATE SUBMITTED: Marchm 28, 2003

16. RETURN TO:
DEPARTMENT OF COMMUNITY HEALTH
MEDICAL ASSISTANCE PLANS
2 PEACHTREE STREET, N.W.
ATLANTA, GEORGIA 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: April 3, 2003

18. DATE APPROVED: May 30, 2003

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Rhonda R Cottrell

21. TYPED NAME: Rhonda R. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS:
Approved with the following pen and ink change to Attachment 4.19-C, page 1, 1st bullet, Item 3: Changed the word "patients" to the word "residents".

FORM HCFA-179 (07-92)

PAYMENT FOR RESERVED BEDS

Regular state payment is permitted for reserving beds during a recipient's absence from an inpatient facility with the following limitations:

1. The patient's plan of care provides for absences, other than hospitalization.

2. Seven (7) days per hospitalization for Medicaid patients who are hospitalized during a stay in a nursing facility.

3. Planned therapeutic home visits.

   - For nursing facility care ~~patients~~ residents up to eight (8) days in any calendar year with no limit on the number of days per visit

   - For ICF-MR residents up to thirty (30) days per calendar year with no limit on the number of days per visit.

4. Alternative health services clients up to and including seven (7) days on a trial visit to an alternative living home when authorized by the client's physician without reduction in payment to the SNF or ICF. Only two such trial visits may be authorized during any calendar year.